No. 49569-4-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

CHEHALIS CHILDREN'S CLINIC, P.S.,

Appellant

v.

WASHINGTON STATE HEALTH CARE AUTHORITY,

Respondent

BRIEF OF APPELLANT

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A. INTRODUCTION

This appeal involves the first in a line of administrative appeals by the Appellant, Chehalis Children's Clinic, P.S. ("CCC", "the Clinic" or "the Appellant"), disputing the findings and Notices of Overpayment claimed by the Washington State Health Care Authority ("HCA" or "the Agency") as a result of managed care reconciliations done by the HCA for calendar years 2009, 2010 and 2011-2013. This appeal deals only with the 2009 reconciliation but the primary issues for each reconciliation and claim of overpayment by HCA are similar. As to the administrative appeals by CCC for 2010 and 2011-2013, the HCA and CCC have agreed to stay those proceedings pending the final outcome of this appeal regarding the 2009 reconciliation claim of overpayment.[1]

B. ASSIGNMENTS OF ERROR AND ISSUES

ASSIGNMENT OF ERROR:

Did the Order Denying Petition by the Thurston County Superior Court and the Review Decision and Final Order of the Health Care Board of Appeals properly decide that the doctrine of equitable estoppel as outlined in WAC 182-526-0495 does not preclude recovery by the HCA of the claimed overpayment?

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1 Chehalis Children's Clinic is only one (1) of other Rural Health Clinics that are affected by the same reconciliation process and claims for overpayment by HCA.

ISSUES PERTAINING TO ASSIGNMENT OF ERROR:

1. Did CCC prove the five (5) necessary elements of equitable estoppel as enumerated in WAC 182-526-0495?

It is the position of Appellant that the Findings of Fact and Conclusions of law enumerated by ALJ Whitehurst as to the doctrine of equitable estoppel precluding collection of the overpayment were correct[2] and the Health Care Board of Appeals' Findings of Fact 8, 11, 12, 20 and 30 are incorrect and the Conclusions of Law, 13, 14, 15, 19, 20, 21, 23, 24, 25, 26, 27 and 28 are improper.

2. CCC finds error in other Findings of Fact and Conclusions of Law enumerated in the Health Care Board of Appeals Review Decision and Final Order that are not related to the issue of equitable estoppel and therefore does not cite those errors in this brief and does not admit as verities any Findings of Fact and Conclusions of law that are unrelated to the issue of equitable estoppel.[3]

C. STATEMENT OF THE CASE

Procedural History.

On December 31, 2014, Appellant (CCC) appealed the "Final Findings and Notice of Overpayment For 2009 Managed Care

2 Clerk's Papers (CP) 54; Administrative Record (AR) AR 54-56
3 CP 56-67, Petitioner's Opening Brief, page 5, lines 9-11

Reconciliation" from the Health Care Authority (HCA) claiming a flawed reconciliation process, that the HCA actually owed Appellant for unpaid enhancement payments, and even if the reconciliation process was not flawed, the HCA was estopped from collection pursuant to the equitable estoppel provisions of WAC 388-02-0495.[4]

Hearing was scheduled to be held on April 1, 2015 and was also continued to April 20, 2015 before an Administrative Law Judge (ALJ) under Docket No 01-2015-HCA-06157.[5] Both parties filed a Hearing Memorandum.[6] ALJ Audrey Whitehurst conducted the hearing and entered her Initial Order on May 8, 2015 upon extensive findings of fact and conclusions of law to support her Order that while the HCA overpaid CCC, the doctrine of equitable estoppel precludes collection of the overpayment.[7]

The HCA appealed ALJ Whitehurst's Initial Order by filing a Petition for Review to the Health Care Authority Board of Appeals as to the equitable estoppel issue claiming that the doctrine of equitable estoppel does not preclude collection, claiming that all five elements of the doctrine had not been established.[8] CCC did not appeal the

4 CP 54; AR 103 - 104
5 CP 54; AR 80-84 & 60-62
6 CP 54; AR 66-71 & 72-76
7 CP 54; AR 40-57
8 CP 54; AR 35-39

ALJ Initial Order, however, did file a Response to the HCA Petition for Review arguing the decision of ALJ Whitehurst as to equitable estoppel as articulated in paragraphs 5.22 through 5.28 of the Initial Order was appropriate and should be upheld.[9]

On August 10, 2015, Review Judge Clayton King of the Health Care Authority Board of Appeals ruled that the Initial Order allowing equitable estoppel was reversed and that the HCA may recover the overpayment.[10]

CCC appealed that ruling and timely filed its Petition for Judicial Review of Agency Action in this matter before the Thurston County Superior Court on September 8, 2015.[11] Judge Gary Tabor entered his Order Denying Petition on October 7, 2016.[12] This appeal was timely filed on October 28, 2016.[13]

Factual Background.

CCC is a federally-qualified Rural Health Clinic (RHC)[14] as defined in WAC 182-549-1100 (formerly WAC 388-549-1100).[15] CCC contracts with the HCA to provide Medicaid-funded services and to

9 CP 54; AR 25-27
10 CP 54; AR 00-21
11 CP 3-53
12 CP 122-125
13 CP 126-131
14 CP 54; Agency Report of Proceedings (RP) 17, lines 15-25 and 18, lines 1-10
15 CP 54; AR 134-135

receive payment.[16] The Centers for Medicare & Medicaid Services (CMS) oversee the payments made to RHCs in compliance with Title XVIII of the Social Security Act (the Act) under section 1902(bb) of the Act [42 U.S.C. 1396a(bb)]. Among other responsibilities, the HCA must administer the payments made to RHCs as outlined in sections 1902(bb) of The Act in accordance with the Washington State Plan (SPA) under title XIX of the Social Security act that became effective July 1, 2008 as approved by CMS.[17]

> The SPA provides as follows:
> For clients enrolled with a manage care contractor, the State will pay the clinic a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, called enhancements, will be paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.[18]

The HCA is further required by WAC 182-549-1400 to pay monthly enhancement payments to RHCs for each client enrolled with a managed care organization (MCO). The HCA sets the enhancement rate that it will pay and notifies each RHC as to the enhancement rate they will receive. For 2009, the enhancement rate to be paid to CCC from the HCA was set by an actuarial firm at the rate of $18.41 per

16 CP 54; AR 137-140
17 CP 54; AR 121-125
18 CP 54; AR 125

member per month.[19] The RHC provides no input or invoice to the HCA into the amount set or paid to them by the HCA for the enhancement. They simply have to rely upon the payment being the correct amount.[20]

To ensure the appropriate enhancement amounts are being paid to each RHC, the HCA is supposed to perform an annual reconciliation to verify that enhancement payments made in the previous year have been made in compliance with section 1902(bb)(5)(A) of the Act.[21]

In 2014, (5 years after the enhancement payments were made) the HCA finally performed a reconciliation of payments made in 2009 by the HCA and certain Managed Care Organizations (MCO) to the RHCs[22]. Obviously the HCA did not timely reconcile the payment made as required by the SPA and WAC 182-549-1400 as the reconciliation was not performed on an "annual basis" the year after payments had been made.

On December 3, 2014, the HCA sent a letter referenced as "Final Findings and Notice of Overpayment For 2009 Managed Care

19 CP 54; AR 127 & 108-112; RP 20, lines 11-17
20 CP 54; RP 55 line 17 through 57, line 7
21 CP 54; AR 125
22 CP 54; AR 132-133

Reconciliation".[23] That is the letter that spawned the underlying appeal by CCC. For the prior 5 years since the enhancement payments had been made to Appellant, they had no idea the amount paid was incorrect in any way. The Appellant only receives a check for payment each month; the Agency does not even send any back-up to show how the check is calculated.

D. LEGAL ANALYSIS AND ARGUMENT

Standard of Review.

The standards for review of agency orders in adjudicative proceedings are set out in RCW 34.05.570. In this case, CCC argues that the decision by the Health Care Authority Board of Appeals overturning the Initial Order by ALJ Whitehurst is not a correct decision under the following standards of RCW 34.05.570:

> (d) The agency has erroneously interpreted or applied the law;
> (e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;

The reviewing court reviews de novo, for legal error whether the agency has erroneously interpreted or applied the law. *Spokane County v. Eastern Washington Growth Management Hearings Bd.*

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23 CP 54; AR 105-106

176 Wn.App. 555, 565, 309 P.3d 673, 678, review denied 179 Wn.2d 1015, 318 P.3d 279 (2013). The court applies the substantial evidence review standard to challenges under RCW 34.05.570(3)(e), determining whether there exists " 'a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness of the order.' " *Id,* citing *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hr'gs Bd.,* 136 Wn.2d at 46, 959 P.2d 1091 (1998), (quoting *Callecod v. Wash. State Patrol,* 84 Wn.App. 663, 673, 929 P.2d 510 (1997)).

ISSUE NO. 1. Did the Appellant prove the five (5) necessary elements of equitable estoppel as enumerated in WAC 182-526-0495?

Reaching an answer to this question requires a review of the hearing testimony and administrative record within the Agency Transcript at Clerk's Papers No. 8. Below is the assignment of error as to the Findings of Fact and Conclusions of Law from the HCA Board of Appeals.

Error in Findings of Fact:

Many of the Findings of Fact of the HCA Board of Appeals are not consistent with the record nor with the findings of the ALJ that heard the testimony of the witnesses during the administrative hearing

requested by CCC. Specific error is assigned to the following Findings of Fact:

Number 8: The description of an enhancement payment, how an enhancement payment is calculated and how an enhancement payment is paid to an RHC is incorrect and does not comport with the description, method of calculation and method of payment outlined in WAC 182-549-1100 and WAC 182-549-1400. An enhancement payment is not just defined as "a monthly amount paid to RHCs for each client enrolled with a managed care organization (MCO)"[24] it is further defined as payment received "...from the department in addition to the negotiated payments they receive from the MCOs for services provided to enrollees." The fact that enhancements are "in addition to" other payments made to the RHC is the most critical part of the definition and the failure of the HCA Board of Appeals to consider that fact in their Findings of Fact is an obvious and fatal error. This fundamental concept is the foundational piece to CCC's argument; something that is in addition to something else cannot be reduced by the very payment it is in addition to.

Further, the statement that "enhancement payments are made in addition to the negotiated payment the RHC receives from the

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24 CP 54; AR 2

MCO for the same services" is not a correct finding of fact. Enhancement payments are not even related to services, so to find that enhancements are in addition to the "same services" paid by the MCO is error.

Number 11: The statement that "the Department performs an annual reconciliation" is an incorrect finding of fact. Under the WAC, the HCA is required to perform an annual reconciliation; however, the HCA did not in fact reconcile 2009 until 2013; that is not an annual reconciliation as required under the WAC and to make a finding that the Department does perform an annual reconciliation is error.

Number 12: The finding that the State will recoup any overpayment of an enhancement is not factually supported by the record. While that is what the HCA claims, it is not the policy outlined in neither the State Plan Amendment (SPA), nor any other official document or regulation administered by CMS. The purpose of the enhancement is to assure a RHC is at least paid the minimum amount required by CMS; not to take away any payment made in addition to the minimum amount.[25] The clearest manifestation of the intent of the enhancement payment is articulated by CMS Associate Regional Administrator, Barbara Richards as follows: "The APM and

25 CP 54; AR 117-119, 120, 121,122-125

Prospective Payment System (PPS) will be reconciled annually to assure the APM at least equals the PPS rate."[26]

Number 20: The statement that "the Agency performs an annual reconciliation of the enhancement payments" is an incorrect finding of fact. Under the WAC, the HCA is required to perform an annual reconciliation; however, the HCA did not reconcile 2009 until 2013; that is not an annual reconciliation as required under the WAC or by CMS.

Number 30: The determination by the Review Judge that "Based upon Exhibit 2 and Finding of Fact 18, this belief was not reasonable" is neither a Finding of Fact nor an appropriate determination and it is not supported by the substantial evidence in the record. Enhancement payments are in fact and by definition "in addition to an encounter payment."

Error in Conclusions of Law:

Number 13: This conclusion is an incorrect interpretation of law. CMS and federal law does not require that the HCA recoup enhancements; that is a total misunderstanding on the part of the HCA. The only requirement is that enhancements must be at least

26 CP 54; AR 121

equal to the encounters paid under either the PPS or APM method as outlined by CMS.[27]

Number 14: This is generally a recitation of arguments of the HCA and CCC which are not conclusions of law. The conclusion that "the Agency position, as set out in Exhibits 6 and 7, is based on the correct reading of the law" is an incorrect interpretation of law. The Agency has misread and misinterpreted the federal law, guidance by CMS and their own SPA. The only statement that is a correct conclusion of law is that the federal statute becomes "the best legal authority available" and is directly controlling. Again, nowhere in the federal statute or in the guidance from CMS or even the SPA is there anything that provides for recoupment of any overpayment of an enhancement; only that they must be at least equal to.[28]

Number 15: This is not a conclusion of law, but is instructive that the testimony of Mr. Collingsworth on accounting principles was not even considered. Mr. Collingsworth testified that it was not proper accounting to offset enhancement from encounters, even under the regulatory payment structure dealing with enhancements.[29]

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27 CP 54; AR 117-119, 120, 121,122-125
28 CP 54; AR 117-119, 120, 121 & 122-125
29 CP 54; RP 83, lines 19-25 84, lines 1-20

Numbers 19, 20 and 21: These are not conclusions of law for the most part and are incorrect interpretations of the law as to reasonable reliance; the correct interpretation is found by ALJ Whitehurst at Conclusion of Law number 5.24.[30] In addition, CCC has nothing to do with any part of the enhancement payments; they don't set the rate, they don't set the client rosters for the MCO, they don't do any calculation of the enhancement payment due each month; they just get a check with no explanation.[31]

Numbers 23, 24, 25 and 26: These are not conclusions of law for the most part and the conclusion that CCC had not proven by clear and convincing evidence that a manifest injustice would occur by permitting recoupment is not factually supported by the evidence and is an incorrect interpretation of the law; the correct interpretation is found by ALJ Whitehurst within Conclusion of Law number 5.26.[32] There is no evidence that anyone knew the enhancements were paid incorrectly; in fact, the evidence in the record supports that even the HCA had no idea if the enhancements were paid correctly. The substantial evidence from federal statute, CMS guidance and the SPA

30 CP 54; AR 54 & 55
31 CP 54; RP 55 - 56
32 CP 54; AR 55 & 57

all indicate that the enhancements were properly calculated. As previously stated, the overwhelming evidence is that enhancements merely have to be at least equal to PPS or APM; there is no requirement that any portion of the enhancement be paid back to HCA or to CMS. Interestingly, there is no evidence that CMS has ever requested repayment of any funds they advanced to HCA in order for HCA to make payment of enhancements to RHCs.

Number 27: This is an incorrect interpretation of law as to whether the exercise of government function would be impaired; preventing the HCA from collecting the assessed overpayment will not prevent the HCA or any other agency in state government from reconciling payments; only the collection of an improper overpayment. The correct analysis and conclusion of law is stated by ALJ Whitehurst within Conclusion of Law number 5.27.[33] HCA did not apply the law correctly and as between the parties here; the HCA is 100% at fault for any overpayment. The HCA holds all the keys in determining the amount of enhancement payment they make; CCC is merely the recipient of the funds. There is no federal law requirement that HCA recoup any part of the enhancement payment; only that it pay at least equal to PPS or APM. Had the federal government (or

33 CP 54; AR 56

CMS specifically) required HCA to recoup overpayments, it would have clearly stated that in the law or guidance from CMS to HCA and would have required that be part of the SPA as well. The fact that CMS does not request or require any repayment for any of the enhancement funds it provides HCA speaks volumes about the fact that recoupment is not required and that the exercise of government function is not going to be impaired if any overpayment is not recouped.

Number 28: CCC did establish all five criteria to prove their entitlement for the application of the doctrine of equitable estoppel by clear and convincing evidence. The HCA Board of Appeals has provided no credible evidence to rebut the evidence presented by CCC; only argument.

Equitable Estoppel under WAC 388-02-0495 is outlined as follows:

> (1) Equitable estoppel is a legal doctrine defined in case law that may only be used as a defense to prevent the department from taking some action against you, such as collecting an overpayment. Equitable estoppel may not be used to require the department to continue to provide something, such as benefits, services, or a license, or to require the department to take action contrary to a statute.
> (2) There are five elements of equitable estoppel. The standard of proof is clear and convincing evidence. You must prove all of the following:

(a) The department made a statement or took an action or failed to take an action, which is inconsistent with a later claim or position by the department. For example, the department gave you money based on your application, then later tells you that you received an overpayment and wants you to pay the money back based on the same information.
(b) You reasonably relied on the department's original statement, action or failure to act. For example, you believed the department acted correctly when you received money.
(c) You will be injured to your detriment if the department is allowed to contradict the original statement, action or failure to act. For example, you did not seek help from health clinics or food banks because you were receiving benefits from the department, and you would have been eligible for these other benefits.
(d) Equitable estoppel is needed to prevent a manifest injustice. Factors to be considered in determining whether a manifest injustice would occur include, but are not limited to, whether:
(i) You cannot afford to repay the money to the department;
(ii) You gave the department timely and accurate information when required;
(iii) You did not know that the department made a mistake;
(iv) You are free from fault; and
(v) The overpayment was caused solely by a department mistake.
(e) The exercise of government functions is not impaired. For example, the use of equitable estoppel in your case will not result in circumstances that will impair department functions.
(3) If the ALJ concludes that you have proven all of the elements of equitable estoppel in subsection (2) of this section with clear and convincing evidence, the department is stopped or prevented from taking action or enforcing a claim against you.

CCC has proven by clear and convincing evidence all five elements of equitable estoppel as found by ALJ Whitehouse and is entitled to keep all the enhancement payments made. The arguments forwarded by the HCA Board of Appeals are not persuasive and not supported by the record when the evidence is properly viewed. There is not a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness of the HCA Board of Appeals Review Decision and Final Order and this Court should reverse the Order that reversed the Initial Order of ALJ Whitehurst.

E. CONCLUSION.

1. That the Court of Appeals reverse the ruling of the Thurston County Superior Court and the Decision and Final Order of the HCA Board of Appeals dated August 10, 2015 and re-affirm the ruling in the Initial Order of the Administrative Law Judge that the doctrine of equitable estoppel precludes the collection of the assessed overpayment in 2009 of $74,634.00.

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2. That the Court tax the HCA for the Appellant's costs of this Petition, including but not limited to the costs of filing the Petition, costs of preparing the record, and for reasonable attorneys' fees

DATED this 20th day of March, 2017.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that on the 20th day of March, 2017 she caused service of this Brief of Appellant to be made upon the Respondent by US Mail, postage pre-paid and by e-mail to:

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Dated this 20th day of March, 2017.

Catherine Hitchman

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